Cascade Health Alliance, LLC

Case Management Referral Form

Date of referral: _____

Member Name: _____ Date of Birth: _____

Address: _____ Member ID #: _____

Phone #: _____ Cell Phone # _____

Referring Provider: _____ Phone #: _____

Reason for Referral

Behavioral Health Concerns

- Seen in the emergency room for behavioral health needs
- Seen in the emergency room for SUD?
- Behavioral health diagnosis with unmet needs

Complex Needs

- High risk pregnancy
- Cancer Diagnosis with unmet needs
- 5 or more chronic condition(s) not well-managed
- Inadequate support system for ADL's and no primary caregiver, or has a primary caregiver with inadequate support
- Requires referral to Community service (SLOCM, KBBH, APD, Housing & Food)
- Transportation to Medical Appointments

Overutilization

- Seen in the emergency room 3 or more times in 6 months
- Over 3 unscheduled acute admissions

Other

2909 Daggett Ave, Suite 225 ● Klamath Falls, OR 97601 ● 541-883-2947 ● Fax: 541-882-6914